CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DEPENDENT CARE ASSISTANCE PLAN

ENROLLMENT FORM for the FY2013 PLAN YEAR (Begins July 1, 2012)

The DCAP program is for reimbursement of dependent care expenses, such as child daycare and elder daycare. DCAP IS NOT FOR REIMBURSEMENT OF A DEPENDENT'S MEDICAL EXPENSES.

Last Name: _____ First Name: _____ Middle Initial: ___ Agency: _____

SSN: _____ Home Phone: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

☐ **Benefit Choice**

☐ **Initial Enrollment (due to beginning employment) - New Hire Date:**_____

☐ **Mid-Year Enrollment – Change in Status Code required (see chart below)** _____

I certify that the above eligible change in status event occurred on _____ /_____ /_____ and that the change is ***on account of and consistent with*** the nature of the qualifying event.

The number of deductions for semi-monthly or bi-weekly payrolls is 24; monthly payrolls is 12 (may be less for university employees).

DEDUCTION AMOUNT $_____ X _____ = $_____

Deduction Amount Per Pay | Number of Deductions | Total Annual DCAP Amount (Minimum $240; Maximum $4999.92)

Change in Status Code Chart

01	Adoption of dependent *
02	Marriage
03	Divorce, legal separation or annulment *
08	Judgment, decree or court order *
10	Employee commences employment
11	Employee returns to active employment (from being on a leave of absence)

13	Employee changes employment status from Part-time <50% to Full-time
14	Spouse commences employment
16	Spouse returns from leave of absence
18	Spouse changes employment status from Part-time to Full-time
21	Change in the cost of care †
24	Coordination of spouse's annual benefit election period †

*** Reviewed case-by-case**

† **Change in Status codes with this symbol** must include a written statement explaining the reason for the request to change the amount or revoke participation in the program. Additionally, if your change in status code is '24', you must also include in your statement what the change was that your spouse made during their election period. Your change must be ***on account of and consistent with*** the change your spouse made.

I understand and certify that:

- *I may not change or stop my deposits to this account during the plan year unless I experience a qualifying change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period, which is September 30th.*
- *I understand that I cannot submit claims for expenses incurred during periods when my spouse or I are not actively working or actively looking for employment.*
- *I intend to participate in DCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.*
- *I will refund any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a deduction was taken.*
- *I understand that if either my spouse or I earn less than $5,000.00, my DCAP contribution cannot exceed the lowest income.*
- *I understand that if my spouse is a full-time student or incapable of self-care, my DCAP contribution cannot exceed $250.00/month for one dependent or $416.66/month for two or more dependents.*
- *I understand that if my spouse and I file separate federal income tax returns, my DCAP contribution cannot exceed $2,500.00.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service and I will comply with the IRS requirement to file an IRS Form 2441.*

By signing this form, I authorize the State of Illinois to deduct the amount indicated from each paycheck for my DCAP account.

Employee Signature: _____ **Date** _____ /_____ /_____

GIR USE ONLY

Org Proc Code: _____ Pay Code: _____ Telephone: _____

Effective Date: _____/_____/_____ Deduction Start Date: _____/_____/_____

Enter a Deduction End Date if enrollment is for a university employee paid over 9 months: _____/_____/_____

GIR Signature: _____ Date: _____/_____/_____

GIR Instructions: Forward the original to the FSA Unit at CMS, forward a copy to payroll and retain a copy in the member's file.